PM Form 7.3.3

Medical Director/Clinical Director Seclusion and Restraint Monthly Review Report

Level I facility: (Please check one)
☐ CCC sub-acute – Pineview
☐ Mingus Center
☐ MMHC sub-acute
☐ TGC - ARTC
☐ TGC Inpatient Psychiatric Hospital
☐ WYG sub-acute - Hillside

Month and Year being reviewed: _______________

COMPLETE SECTION 1 OR SECTION 2

SECTION 1:

<table>
<thead>
<tr>
<th>Date of Incident</th>
<th>Client ID</th>
<th>Start Time of S/R</th>
<th>End Time of S/R</th>
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I attest that the above seclusion and restraint incidents have been reviewed.

Medical Director/Clinical Director Signature ______________________ Date __________

SECTION 2:

There were no seclusion or restraint incidents to be reviewed.

Medical Director/Clinical Director Signature ______________________ Date __________